CHAPTER 6
DATA AND REPORTING

6.1   Contractor Requirements

All forms and reports are used by the Community Nursing Program to collect information for program planning, development and evaluation. Information gathered, both at the ADHS and Contractor level is used to evaluate the effectiveness of the Program. In this chapter, data collection forms will be fully explained.

A. The contractor shall notify the ADHS Community Nursing Program Manager of any new professional staff and changes to existing staff within 30 days of the change. This may be done via email or formal letter.

B. The contractor shall maintain the following information for ADHS Site Team Review:

1. Documentation of Orientation/Training for each staff member providing visits

2. Proof of current Arizona Nursing Licensure

3. Certification/Licensure for Social Worker or other Early Interventionist staff (includes staff and contractors)

4. Continuing Education for previous year for home visiting staff

5. Annual Review of Nursing Standards of Care for each staff member providing visits

6.2   Reporting Requirements

A. **Monthly Logs/Invoices**

Contractors are required to provide a monthly log (Service Summary) that includes the name of the participant, date of visit and type of service. The monthly log and invoice are to be submitted within 30 days after the end of each month. If the log is incomplete or illegible, it will be sent back to the Contractor for completion before payment is authorized.

B. **Quarterly Reports/Quality Improvement Indicators**

A quarterly report must be submitted within 30 days of the end of the quarter (quarters end September, December, March and June) describing the following:

1. Program strengths, priorities and concerns
2. Goals for the next 3 months
3. Training/education activities, certifications and training needs
4. Continuous Quality Improvement updates (chapter 8)

(1st quarter is July-September the report is due October 31. The 2nd quarter is October-December the report is due January 31st. The 3rd quarter is January-March the report is due April 30. The 4th quarter is April-June the report is due July 31.)

6.3   Forms Completion and Distribution

The CHN must receive a copy of the "*Hospital Discharge Summary*" and "*Request for Participation*" (RFP) forms from the hospital for all infants enrolled in the NICP prior to home visits unless it is a pre-discharge visit.

6.3.1 "Request for Participation" – High Risk Perinatal Program

This form provides demographic information for the family. It also contains the family's signature that verifies enrollment and provides permission for data sharing with other components of the program. This form must be received by the Contractor before home visits are completed.

The Community Health Nurse may be requested to enroll an infant in the program; however, this must have prior approval from the Community Nursing or Hospital Services Program Manager. This might occur when:

- The family was eligible but not signed up in the hospital

- The family initially refused enrollment into the Program and now wishes to enroll.

- The child was in an out-of-state NICU and moved to Arizona after birth.

- The family lives in Arizona but delivers out of state. Contractors in border counties serving many infants who are born out of state may have a working relationship with specific hospitals that refer NICP eligible infants directly to them. For these enrollees, the contractor

would not need to get prior approval; however, the infant is eligible for follow-up service only.

(See the procedures for "Late Enrollments" in Chapter 3, Section 3.4.1)

6.3.2 Request for Participation - Children with Special Health Care Needs

Permission to Participate must be signed by the parent, the hospital or on the first home visit of infants/children who are not enrolled in the NICP. (See Chapter 3 for eligibility and enrollment information.)

6.3.3 Discharge Summary

This form is used to summarize the infant's hospitalization records and discharge data and also functions as the referral form for the CHN. A copy of this form should be given to the appropriate CHN at the time of discharge.

Referrals for out-of-town families are to be sent by hospital personnel to the appropriate community-nursing contractor within 24 hours after discharge. CHN staff attending discharge-planning meetings shall assist the responsible hospital personnel by providing updated CHN lists as needed.

6.3.4 Visit Reporting Form

The Community Nursing Visit Form is a two-page report to be filled out by the home visitor after each visit. Areas shaded in gray do not need to be filled out for infants enrolled in NICP unless there is a change in data. Child's last name, alias, DOB and mother's name are used as an identifier and must always be completed. These forms are used for any home visit whether provided by nurses, social workers or early interventionists to a family enrolled in NICP, CSHCN or receiving a visit for Newborn Screening. If the visit is conducted by an EI, it must be clearly indicated across the top of the visit form. *Other policies include:

a. Copies of page 1 and 2 of the visit forms must be "stapled" together and returned to the Community Nursing Program Manager with the monthly invoice.

b. The white copy of the Community Nursing visit form is filed in the client's chart.

c. Forms not filled out completely or legibly will be considered incomplete and returned to the Contractor for completion before reimbursement is approved.

d. The entire visit form must be completed on the first visit for OCSHCN enrollees. Since the mother and infant are "linked" in the data system, the mother's information is mandatory.

e. "Alias" names must be provided on each nursing form as data managers do not have previous information at hand when entering a visit form. The initial forms from the hospital are the ones entered first into the data system and therefore; the child's actual name may appear as an alias in the data system.

f. All non-shaded fields must be filled in. Referrals and barriers must be completed using the letter coding system, see reference table at the end of this chapter. If there is no appropriate code simply use a zero with a slash through it.

g. The data system is set up to receive specific field values selected by ADHS and OCSHCN that enable the programs to collect complete and consistent data. This data will be used to "paint a picture" of the critically ill newborns and their progress (outcomes). Please refer to reference tables at the end of this chapter.

h. **Health Status**

   "Good" when they have normal growth and development parameters:

   - Consistent growth, height, weight and head circumference as indicated on the growth charts and the other assessment information collected by the CHN's.

   - No trips to the ER, no medications needed except vitamins, normal physical exam and no family or CHN concerns.

   "Fair" when child has had normal childhood illnesses such as ear infection or:

   - A chronic condition exists that does not require frequent trips to the doctor or hospitalizations.

   - Feeding problems exist but the child's growth parameters are still on the growth chart.

   - Some equipment, such as apnea monitor and/ medications are taken such as those for seizures, etc.

"Poor" when they have conditions that may be considered "life threatening" or need frequent hospitalizations or surgeries.

i. **Medical Home** - ADHS will use the American Academy of Pediatrics (AAP) definition of medical home as ideal. However, that definition is very restrictive. Therefore, please mark "yes" for medical home if the family has a consistent source of medical care, such as:

- A physician or practitioner they can call if their child is sick anytime within a 24-hour period of time.

- A place they can take their child for care other than an emergency room, i.e., Doctor's Office, clinic, community health center, etc.

j. **Service**
Please be sure to check both where the visit was located (local, out-of-town, out of county) AND the type of visit (interim, regular, staffing, bereavement, pre-discharge) (chapter 7).

k. **Purpose of CNS Visit**
This field should be utilized to provide additional detail regarding the purpose of the visit and is particularly important when there is a need for multiple visits within a short period of time. Using as few words as is possible; the home visitor should describe the ongoing situation. ie: uncontrolled diabetes, repeated hospitalizations, homelessness, domestic violence, et al.